	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
MIDILAN	or condetion	155785	A. BUILDING B. WING		10/06/2011
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEF	R		EICKHOFF RD	
WEST R	IVER HEALTH CAN	MPUS		VILLE, IN47712	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
F0000	REGULATORY OR	. LSC IDENTIFY ING INFORMATION)	TAG	DIA (CILACT)	DATE
10000					
	This visit was fo	r the Investigation of	F0000		
	Complaint IN00	_			
	-				
	This visit was do	one in conjunction with			
	the Post Survey	Revisit (PSR) to the			
	_	Complaint IN00095419			
	completed on Se	ptember 6, 2011.			
	Complaint IN00096308 Substantiated,				
	Federal/State deficiencies related to the				
	_	ited at F157, F241, F282,			
	F514				
	Survey dates: O	ctober 5 and 6, 2011			
	Facility number:	012448			
	Provider number				
	AIM number: N	/A			
	Survey team: A	nne Marie Crays RN			
	Census bed type	:			
	SNF: 26				
	Residential: 52				
	Total: 78				
	Conque marram to	20.			
	Census payor type Medicare: 19	μ c .			
	Other: 69				
	Total: 78				
	10141. 70				
	Sample: 5				
LABORATOR	RY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SIG	GNATURE	TITLE	(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/04/2011 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155785	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM 10/06	TE SURVEY MPLETED 6/2011
NAME OF F	PROVIDER OR SUPPLIEF	·		ADDRESS, CITY, STATE, ZII EICKHOFF RD	P CODE	
WEST R	IVER HEALTH CAN	MPUS		VILLE, IN47712		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	These deficienci findings cited in 16.2.	es also reflect state accordance with 410 IAC		CROSS-REFERENCED TO TH	HE APPROPRIATE	

012448

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155785		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/06/2011	
NAME OF PROVIDER OR SUPPLIER WEST RIVER HEALTH CAMP	PUS	STREET 714 S	SADDRESS, CITY, STATE, ZIP CODE EICKHOFF RD SVILLE, IN47712		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PERCEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
and if known, notify representative or at when there is an act resident which result potential for requirit significant change it mental, or psychosocial status conditions or clinical alter treatment significant change it discontinue an exist to adverse consequence form of treatments for or discharge facility as specified. The facility must also resident and, if knot representative or in when there is a character of the charac	ith the resident's physician; it the resident's legal in interested family member ecident involving the alts in injury and has the ing physician intervention; a fin the resident's physical, ocial status (i.e., a alth, mental, or in either life threatening al complications); a need to difficantly (i.e., a	F0157	F157 Resident B's MAR an physcian orders were compared to ensure accuracy andavailability. Staff that administer medication to her been inserviced on those orders.Completion Date 10-31-11Residents A's MAR TAR have been compared to ensure accuracy and staff the public of the compared to	have and o at	

TN4711

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155785 10/06/2011 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 714 S EICKHOFF RD WEST RIVER HEALTH CAMPUS **EVANSVILLE, IN47712** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5)PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE administer medication to him have been inserviced on those 1. The clinical record of Resident B was orders.Completion Date reviewed on 10/5/11 at 2:25 P.M. A 10-31-11No other residents were Physician's order, dated 8/25/11, affected by the deficient practice and through inservicing and indicated, "Ondonsetron [otherwise alteration in documentation known as Zofran, for nausea] 4 mg tab PO will ensure that medications that [by mouth] QAM [every morning] before are not administered as they are rising et [and] PRN [as needed] Q [every] ordered will have reason why and 6-8 [hours] nausea/vomiting x 7 days." A documentation of physcian notification.Completion Date MAR, dated August 2011, indicated a 10-31-11Licensed nursing staff blank space on 8/26, and circled initials inserviced on proper medication on 8/27, 8/28, and 8/29. Documentation administration procedures, of an explanation for the circled initials documentation of physician notification related to meds when was lacking. held, refused or omitted.Completion Date A hospice note, dated 8/30/11, indicated, 10-31-11DHS/Designee will "...Drug: Ondonsetron observe 1 nurse per day during med administration rotating shifts (Zofran)...effective? Other: had not been and hallways, and fill out given...Mood: upset about lack of observation report upon care/meds given...Summary of visit...Pt completion with identified [patient] very nauseated. Zofran not concerns related to dosage. technique, timeframes, started but in Pt's med drawer. This HRN documention, etc. Audits will be [hospice nurse] administered Zofran...." for 15 days, then 1 per week for 30 days, then 1 mothly. A hospice note, dated 8/31/11, indicated, Pharmacist will also randomly observe 1 nurse med pass per "...Pt states better since Zofran month.Results of audits will be started...Spoke to ADON [Assistant forwarded to QA committee Director of Nursing] [name] re: problem monthly x 6 months and quarterly [with] pt getting meds when due...." thereafter. A Medication Administration Record. dated September 2011, indicated, "Requip 2 mg Give 1 tablet by mouth every bedtime for restless leg syndrome."

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155785		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL 10/06/2	ETED	
	PROVIDER OR SUPPLIER		F	STREET A	ODDRESS, CITY, STATE, ZIP CODE ICKHOFF RD VILLE, IN47712	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
120	Circled initials w and 9/14. The re- indicated: "9/8/1 give Requip. 9/1 Requip. Unavaila 9/14/11 Unable t Pharm [sic]."	vere on 9/8, 9/10, 9/13, verse of the MAR 1 Unavailable. Unable to 3/11 Not able to give able. Pharm faxed. o give Requip. Fax		TAG			DAIL
	"Spoke to ADC conference D/T [ON [name] re: care due to] meds missing, ic]. Will schedule ASAP					
	Documentation of the resident no medications was	· ·					
	with the Administraction and control that corporate sta	15 P.M., during interview strator, she indicated the re of the issue of locumentation issues, and aff had been in the facility appling to inservice and					
	interview with R he had resided at approximately 10 time the staff had medication order A indicated there) months, and during that					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155785	A. BUILDI		00	(X3) DATE : COMPL 10/06/2	ETED
NAME OF PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE	1	-
WEST RIVER HEALTH CAM	PUS	Į E	EVANSV	/ILLE, IN47712		
PREFIX (EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID EFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
creams.						
	rd of Resident A was 7/11 at 10:30 A.M.					
Record [MAR] in HCTZ [blood premg capsule, Give every morning. The blank. Entries on 6/17, and 6/18 we potassium Citrate times daily with a con 6/3 and 6/4 lu 6/11-6/16 supper 6/17 and 6/18 sughth and on 6/1 Doxycycline 100 daily, Stop 7/16. 6/5 supper. Keflet QID [four times con 6/4 lunch and supper. Altabex to [twice daily] x 3 blank on 6/2, 6/3 6/3, 6/4, 6/5, and apply topically to Entries were blar "6P-6A." Silvade after nystop power Entries were blar	mg [antibiotic] twice An entry was blank on ex 500 mg [antibiotic] daily]. Entries were blank supper, 6/5 supper, 6/6 o [left] great toe bid weeks. Entries were , 6/4 at "6A-6P," and on 6/6 at "6P-6A." Nystop b buttocks twice daily. ak on 6/3, 6/5 and 6/7 at ene apply to buttocks der applied twice daily. ak on 6/3, 6/5, and 6/7 at with circled initials were					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155785		A. BUI	LDING	NSTRUCTION 00	(X3) DATE : COMPL 10/06/2	ETED	
NAME OF F	PROVIDER OR SUPPLIEF		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE	10/00/2	011
WEST R	IVER HEALTH CAN	MPUS			ICKHOFF RD VILLE, IN47712		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	Explanation of the initials was lacking	he blanks or circled ing.					
	Clean bilateral p normal saline. A Cover [with] AE 2-10. Entries we through 8/28. En were on 8/24, 8/3 of the blanks or lacking. A MAR, dated S "Clean bilateral [normal saline], wound bed. Cov wrap [with] kerliblank on 9/1, 9/1 and 9/28. Circled Explanation of the initials was lacked. On 10/6/11 at 11 interview with the Director of Nurs they indicated the times if the residuant to pay for a would not cover.	August 2011, included: osterior groin [with] pply silver powder. BD pad, wrap with kerlix. re blank from 8/25 attries with circled initials 29, and 8/30. Explanation circled initials was deptember 2011, included: posterior groin [with] NS Apply silva powder to er [with] ABD [and] ix daily. Entries were 10, 9/11, 9/23, 9/24,9/25, d initials were on 9/26. The blanks or circled ing. 1:30 A.M., during the Corporate Nurses, ing, and Administrator, there was a conflict at then or family did not medications that insurance the outfield if the					
	1 * *	t receive an ordered					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF CORRECTION	IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE COMPL	
		155785	A. BUI B. WIN	LDING		10/06/2	
			B. WIIV		DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	8			ICKHOFF RD		
WEST RI	VER HEALTH CAN	MPUS		EVANS	VILLE, IN47712		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG	3. On 10/5/11 at			TAG	DEFICIENCE)		DATE
		ovided the current facility					
	_	cation Administration -					
		nes," dated 2/10. The					
	policy included:	" If one dose of a vital					
		vithheld or refused, the					
	physician is noti	fied."					
	This federal tag	relates to Complaint					
	IN00096308.	relates to Complaint					
	11 (000) 02 00.						
	3.1-5(a)(1)						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155785 10/06/2011 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 714 S EICKHOFF RD WEST RIVER HEALTH CAMPUS **EVANSVILLE, IN47712** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5)PROVIDER'S PLAN OF CORRECTION ROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE The facility must promote care for residents in F0241 a manner and in an environment that SS=E maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. F241 Res A suffered no ill effects Based on interview and record review, the F0241 10/31/2011 from findings on the 2567L. facility failed to ensure call lights were Resident was assessed to answered in a timely manner, for 2 of 3 determine identified need was residents interviewed in a sample of 5, met and assistance was and for 7 residents listed in Resident offered. Completion Date 10-31-11Resident D sufferd no ill Council Minutes. Resident A, Resident D effects from findings on 2567L. Resident was assessed to Findings include: determine identified needs were met and assistance was offered.Completion Date During confidential interview with 10-31-11All residents who utilize Resident A, alert and oriented as indicated their call lights to communicate on a roster provided by the Administrator their needs for assistance have the potetial to be affected by the on 10/5/11 at 11:40 A.M., the resident alleged deficient practice and indicated "it takes a long time" for call through inservicing and quicker lights to be answered. The resident response time will meet resident indicated nurses at times will turn off the needs.Completion Date call lights, but not respond to the requests. 10-31-11Resident Council will establish acceptable response The resident indicated the call light has time. Systemic changes include been on for up to 45 minutes before staff inservicing of all departments to has responded. answer call lights with instructions to find a caregiver within established response time. During confidential interview with In-Service includes leaving light Resident D, an alert and oriented resident on for other departments if it as indicated on a roster provided by the requires a nursing caregiver to Administrator on 10/5/11 at 11:40 A.M., meet the need.Completion Date 10-31-11Call light response will the resident indicated he/she was to be monitored by nursing receive assistance of staff to transfer, "and management and department sometimes just can't wait and go by heads to ensure staff responds myself." The resident indicated he/she within the established parameters. Compliance rounds was unsure how long it took for call lights

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER				NSTRUCTION 00	(X3) DATE : COMPL		
		155785	A. BUII B. WIN	LDING G		10/06/2	
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>		STREET A	DDRESS, CITY, STATE, ZIP CODE		
					ICKHOFF RD		
	VER HEALTH CAM			<u> </u>	VILLE, IN47712		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
	to be responded to minutes or longer he/she would be when I don't have On 10/5/11 at 2: Administrator programmer Minutes, dated 9 indicated 7 resident The minutes incluminated 10 minutes incluminated 11 minutes incluminated 12 minutes incluminated 12 minutes incluminated 13 minutes incluminated 13 minutes incluminated 14 minutes incluminated 15 minutes incluminate	to, but "guessed it was 15 r." The resident indicated better off "next week, e to wait for help." 15 P.M., the ovided Resident Council /27/11. The minutes ents were in attendance. uded: "NRSNG rall lights are being." 130 P.M., during the Administrator, she is unsure if the facility procedure related to ghts, but that the dard was to respond to			CROSS-REFERENCED TO THE APPROPRIAT	y for ght phose lts of il	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155785			(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 10/06/2011	
	ROVIDER OR SUPPLIER		714 S E	ADDRESS, CITY, STATE, ZIP CODE EICKHOFF RD SVILLE, IN47712		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
F0282 SS=D	facility must be proin accordance with plan of care. Based on observation record review, the medications were prescribed by the residents reviewed physician orders, Resident B, C, and Findings include 1. On 10/5/11 at medication pass, administer Resident B administer Resident B, E, and the medication pass, administer Resident B, E, and E,	ephysician, for 3 of 3 ed for following in a sample of 5. and A 11:40 A.M., during a LPN # 1 was observed to ent B a medication for indicated the resident did hal medications to be	F0282	F282Resident B's MAR and physician orders were compato ensure accuracy and availability. Staff that adminimedication to her have been inserviced on those orders. Completion Date 10-31-11Resident A's MAR at TAR have been compared to ensure accuracy and staff that administer medication to him have been inserviced on those orders. Completion Date 10-31-11Resident C no longer resides at the facility. No other residents were affected by the deficient practice and through inservicing and alteration in documentation will ensure the medications that are not administered as they are order will have reason why ad documentation of physician	and at se er er e n	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155785	ĺ	ULTIPLE CO	NSTRUCTION 00	(X3) DATE : COMPL 10/06/2	ETED
		100700	B. WIN			10/06/2	U I I
	PROVIDER OR SUPPLIER			714 S E	DDRESS, CITY, STATE, ZIP CODE ICKHOFF RD VILLE, IN47712		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	ΓE	DATE
	reviewed on 10/5 Physician's order indicated, "Incre supplement] 10 redaily] instead of interviewed at the resident not recereviewed the Me Record [MAR], found the entry we "Potassium Cl 10 mouth TID. Risis medication was reducation was reduced in the supplement of the supplement o	Isc IDENTIFYING INFORMATION) 5/11 at 1:45 P.M. A r, dated 9/26/11, ase KCL [Potassium mEq to TID [three times daily." LPN # 1 was tat time regarding the iving KCL. LPN # 1 then dication Administration dated October 2011, and which indicated: 0 mEq Give 1 capsule by ng, Lunch, Supper." The not initialed as given on r on 10/2, 10/3, 10/4, or # 1 indicated at that time r order, and she "guessed at that time," since it fter lunch. dministration Record, 2011, indicated the KCL initialed as given on 9/29 nch or "HS" [bedtime]. and was reviewed again on P.M. A Physician's order, adicated, "Ondonsetron n as Zofran, for nausea] 4 nouth] QAM [every rrising et [and] PRN [as			CROSS-REFERENCED TO THE APPROPRIATION	aff tion eld, on e will ng shifts fr 30 nacist	
	o, 20, and on old						

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155785	B. WIN	G		10/06/2	011
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					EICKHOFF RD		
WEST R	IVER HEALTH CAN	MPUS		EVANS	VILLE, IN47712		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	and 8/29. Documentation of an explanation for the circled initials was						
	lacking.						
		dated 8/30/11, indicated,					
	"Drug: Ondon						
	` ′	ive? Other: had not been					
		pset about lack of					
		Summary of visitPt					
	[patient] very nauseated. Zofran not						
	started but in Pt's med drawer. This HRN [hospice nurse] administered Zofran"						
		dated 8/31/11, indicated,					
	"Pt states bette						
	•	o ADON [Assistant					
		sing] [name] re: problem					
	[with] pt getting	meds when due"					
	A Medication A	dministration Record,					
		r 2011, indicated, "Requip					
	_	let by mouth every					
	_	less leg syndrome."					
		vere on 9/8, 9/10, 9/13,					
		everse of the MAR					
		1 Unavailable. Unable to					
		3/11 Not able to give					
		able. Pharm faxed.					
		to give Requip. Fax					
	Pharm [sic]."						
	Δ hospice note	dated 9/19/11, indicated,					
	_	ON [name] re: care					
	•	[due to] meds missing,					
	Conference D/ I	[uuc to] meus missing,					

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155785	B. WIN	IG		10/06/2	011
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
WEST		ADLIC			EICKHOFF RD		
WESTR	IVER HEALTH CAN			EVANS	VILLE, IN47712		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG				TAG			DATE
	_	ic]. Will schedule ASAP					
	[as soon as possible]"						
	On 10/5/11 at 3:50 P.M., during interview						
	with the Assistant Director of Nursing,						
		e met with Resident B's					
		garding the omission of					
	_	cated she did not know					
		staff did not administer					
		I not know why the					
	•	eled on the MAR.					
	illitials were ene	ied on the MAK.					
	On 10/6/11 at 1:	00 P.M., during interview					
		ate Nurse, she indicated					
	•	why the Requip was					
		it possibly could have					
	been that hospic						
	•	the facility had run out					
		g the medication.					
	prior to receiving	g the medication.					
	2. On 10/5/11 at	11:40 A.M., LPN # 1					
		give Resident C the					
	following medic	_					
		avix, Potassium Chloride,					
	· · · · · · · · · · · · · · · · · · ·	N # 1 also administered					
	the resident Pror						
	supplement].	[m					
	The clinical reco	ord of Resident C was					
	reviewed on 10/2	5/11 at 1:40 P.M. The					
		nitted to the facility on					
		an orders, dated 9/28/11,					
	_	owing medications:					
		wice daily, Docusate					
	1	J,					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			MULTIPLE CO JILDING	NSTRUCTION 00		(X3) DATE COMPL	ETED	
		155785	B. W	ING			10/06/2	UII
NAME OF F	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STA	ATE, ZIP CODE		
					ICKHOFF RD			
WEST R	IVER HEALTH CAN	MPUS		EVANS	VILLE, IN47712	<u> </u>		
(X4) ID		STATEMENT OF DEFICIENCIES		ID		PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FU		PREFIX	PREFIX (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP		E	COMPLETION
TAG		R LSC IDENTIFYING INFORMATI		TAG	DEF	FICIENCY)		DATE
		aily, Lovenox daily, Lasi						
		ur twice daily, Synthroid	1					
		ily, Metoprolol daily,						
	Multivitamin dai	ily, Prilosec twice daily,						
		tassium Chloride daily,						
	Altace daily, Flo	omax daily and Tricor						
	daily. A Physicia	an's order, dated 10/4/11	,					
	indicated, "Prom	nod 30 cc TID [with] med	d					
	passes."							
	On 10/5/11 at 1:	40 P.M., the resident's						
		ninistration Record						
		ewed. The MAR						
		edications Lipitor,						
		lavix, Potassium Chlorid	e					
	-	e to be administered	·,					
		romod was to be						
		pon rise, Lunch, Supper.	,,					
		ed at that time, that the	•					
		·						
		n refusing some of the						
		he morning, so the staff						
	had been "splitti	•						
		was lacking that the						
		ised medications, or that						
		been administered at						
	different times.							
		inical record was again						
		5/11 at 2:40 P.M. A						
		ord, dated September						
	•	initials and times were						
	lacking for "All	After Rising Meds," "Al	1					
	Lunch Meds," "A	All Supper Meds," and						
	"All Bedtime Me	eds," except for 9/29 and	1					
FORM CMS-2	2567(02-99) Previous Versi	ions Obsolete Event	^{ID:} TN471	1 Facility I	D: 012448	If continuation sh	eet Pa	ge 15 of 29

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION 00	(X3) DATE : COMPL		
THIS TEAU	or conduction	155785	A. BUII			10/06/2	
			B. WIN		DDRESS, CITY, STATE, ZIP CODE		-
NAME OF F	PROVIDER OR SUPPLIER				ICKHOFF RD		
WEST R	IVER HEALTH CAM	1PUS			VILLE, IN47712		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5)
PREFIX TAG	, The state of the	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG			COMPLETION DATE
TAG	9/30 "After Risin	<u> </u>		TAG	BETTELLINETY		DATE
	9/30 Alter Kisii	ig.					
	On 10/5/11 at 2:1	15 P.M., during interview					
		strator, she indicated the					
	facility was awar						
	*	locumentation issues, and					
		aff had been in the facility					
		npting to inservice and					
	retrain staff.						
	3. On 10/5/11 at	9:55 A.M., during					
		esident A, he indicated					
	he had resided at						
) months, and during that					
	time the staff had	_					
		rs several times. Resident					
	A indicated there	e had been several times					
		et his medications and					
	creams.						
	The clinical reco	rd of Resident A was					
	reviewed on 10/5	5/11 at 10:30 A.M.					
	A June 2011 Me	dication Administration					
	Record [MAR] in	ncluded the following:					
	HCTZ [blood pro	essure medication] 12.5					
	mg capsule, Give	e 1 capsule by mouth					
	every morning. T	The entry for 6/8 was					
	blank. Entries on	6/10, 6/13, 6/14, 6/16,					
	6/17, and 6/18 w	ere circled initials.					
	Potassium Citrate	e Give 1 capsule three					
	times daily with	meals. Entries were blank					
	on 6/3 and 6/4 lu	nch, 6/4, 6/5, 6/6,					
	6/11-6/16 supper	. Initials were circled on					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155785			A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPL 10/06/2	ETED
			B. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			ICKHOFF RD		
	IVER HEALTH CAN			EVANS	VILLE, IN47712		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)				TE	COMPLETION DATE
1710		pper, 6/18, breakfast and		1710			DITIE
	lunch, and on 6/3						
	Doxycycline 100 mg [antibiotic] twice						
	daily, Stop 7/16. An entry was blank on						
	6/5 supper. Kefle	ex 500 mg [antibiotic]					
	QID [four times	daily]. Entries were blank					
	on 6/4 lunch and	supper, 6/5 supper, 6/6					
		to [left] great toe bid					
	1	weeks. Entries were					
	-	6, 6/4 at "6A-6P," and on					
		l 6/6 at "6P-6A." Nystop					
		o buttocks twice daily.					
		nk on 6/3, 6/5 and 6/7 at					
		ene apply to buttocks					
		der applied twice daily.					
		nk on 6/3, 6/5, and 6/7 at					
		s with circled initials were					
	on 6/2 at "6A-6P						
	_	ne blanks or circled					
	initials was lacki	ng.					
	Δ MAR datad A	August 2011, included:					
		osterior groin [with]					
	_	pply silver powder.					
		BD pad, wrap with kerlix.					
		re blank from 8/25					
		tries with circled initials					
	_	29, and 8/30. Explanation					
		circled initials was					
	lacking.						
	A MAR, dated S	eptember 2011, included:					
	"Clean bilateral	posterior groin [with] NS					
	[normal saline],	Apply silva powder to					

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155785	B. WIN			10/06/2	011
NAME OF	PROVIDER OR SUPPLIEI		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
					EICKHOFF RD		
WEST R	IVER HEALTH CAN	MPUS		EVANS	VILLE, IN47712		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	· `	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
IAG		R LSC IDENTIFYING INFORMATION)		TAG	DLI ICILIAC I)		DATE
		rer [with] ABD [and]					
	wrap [with] kerlix daily. Entries were blank on 9/1, 9/10, 9/11, 9/23, 9/24,9/25, and 9/28. Circled initials were on 9/26.						
	_	he blanks or circled					
	initials was lack	ing.					
	On 10/6/11 at 11	1:30 A.M., during					
		he Corporate Nurses,					
		sing, and Administrator,					
		nere was a conflict at					
	1	lent or family did not					
		medications that insurance					
		They indicated there					
		nentation on why a					
	medication was	•					
	medication was	missed.					
	4. On 10/5/11 at	4:00 P.M., the					
	Administrator pr	rovided the current facility					
	policy on "Medi	cation Administration					
	Times Procedura	al Guidelines," undated.					
		ded: "Unless a specific					
	1 1	ed by the attending					
	physician medic	ations shall be					
	1 * *	the following times: a.					
		- after there resident					
	1	orning (morning is					
		nes between 4 AM and 10					
	_	vice daily] - in the					
	1 '	pedtime (bedtime is					
	1	3 PM to Midnight). c. TID					
	1 -	y] - in the morning,					
	_	ne and at bedtime (lunch					
		etween 11 AM and 1:30					

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155785		LDING	NSTRUCTION 00		COMPL 10/06/2	ETED
	ROVIDER OR SUPPLIER		•	714 S EI	DDRESS, CITY, STA CKHOFF RD /ILLE, IN47712	TE, ZIP CODE		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	(EACH CORRECTIVE CROSS-REFERENCE	LAN OF CORRECTION E ACTION SHOULD BE ID TO THE APPROPRIATE		(X5) COMPLETION
	PM)The nurse medications shall medication was a his/her initials. a time of the previadministering the ensure it is not p togetherMedical ordered at a special administered at the attending physical conditions of the attending the machinistering the machinistering the machinistering the machinistering the machinistering the machinistering the conditions of the scheduled time the front of the machinistrations in [sic]. An explanating the reverse side of the provided of the scheduled time the reverse side of the provided of the provid	cy MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) administering the I record the time the administered along with The nurse shall note the ous dose prior to e same medication to rovided too close ations that have been cific time shall be the time designated by vsician."			(EACH CORRECTIVE CROSS-REFERENCE	E ACTION SHOULD BE		
FORM CMS-2	refused, the phys	ons Obsolete Event ID:	TN4711	Facility II	D: 012448	If continuation she	eet Pac	ge 19 of 29

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155785	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	COM	TE SURVEY MPLETED 6/2011
	ROVIDER OR SUPPLIER		714 S E	address, city, state, zii ICKHOFF RD VILLE, IN47712	P CODE	
(X4) ID PREFIX	SUMMARY S	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF C		(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO TH DEFICIENCY)	HE APPROPRIATE	DATE
	This federal tag in IN00096308.	relates to Complaint				
	3.1-35(g)(2)					
F0514 SS=D	each resident in a professional stand complete; accurat	naintain clinical records on coordance with accepted lards and practices that are ely documented; readily vstematically organized.				
	information to ider the resident's asso and services prov	I must contain sufficient ntify the resident; a record of essments; the plan of care ided; the results of any eening conducted by the ss notes.				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155785 10/06/2011 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 714 S EICKHOFF RD WEST RIVER HEALTH CAMPUS **EVANSVILLE, IN47712** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5)PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE F514Resident B's MAR and Based on observation, interview and F0514 10/31/2011 physician orders were compared record review, the facility failed to ensure to ensure accuracy and documentation was complete and accurate availability. Staff that administer on the medication administration record, medication to her have been inserviced on those for 3 of 3 residents reviewed for orders.Completion Date documentation, in a sample of 5. 10-31-11Resident A's MAR and Residents B, C, and A TAR have been compared to ensure accuracy and staff that Findings include: administer medication and treatments to him have been inserviced on those 1. On 10/5/11 at 11:40 A.M., during a orders.Completion Date medication pass, LPN # 1 was observed to 10-31-11Resident C no longer administer Resident B a medication for resides in the facility. No other residents were affected by the nausea. LPN # 1 indicated the resident did deficient practice and through not have additional medications to be inservicing and alteration in administered at that time. documentation will ensure that medications/treatments that are not administered as they are The clinical record of Resident B was ordered will have reason why and reviewed on 10/5/11 at 1:45 P.M. A documentation of physician Physician's order, dated 9/26/11, notification.Completion Date indicated, "Increase KCL [Potassium 10-31-11Licensed nursing staff inserviced on proper medication supplement] 10 mEq to TID [three times administration procedures, daily] instead of daily." LPN # 1 was documentation of physician interviewed at that time regarding the notification related to meds/tx's resident not receiving KCL. LPN # 1 then when held, refused or omitted.Completion Date reviewed the Medication Administration 10-31-11DHS/Designee will Record [MAR], dated October 2011, and observe 1 nurse per day during found the entry which indicated: med administration rotatig shifts "Potassium Cl 10 mEq Give 1 capsule by and hallways, and fill out observation report upon mouth TID. Rising, Lunch, Supper." The completion with identified medication was not initialed as given on concerns related to dosage. 10/2/11 rising, or on 10/2, 10/3, 10/4, or technique, timeframe, 10/5 lunch. LPN # 1 indicated at that time documentation, etc. Audits will be for 15 days, then 1 per week for that it was a new order, and she "guessed

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155795		(X2) M A. BUII		NSTRUCTION 00	(X3) DATE S COMPLI	ETED	
		155785	B. WIN	G		10/06/20	011
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
WFST R	IVER HEALTH CAM	1PUS			ICKHOFF RD VILLE, IN47712		
(X4) ID		FATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	she could give it at that time," since it wasn't too late after lunch.			30 days, then 1 monthly. Pharmacist wll also randomly			
	wasn't too late af	ter lunch.			observe 1 nurse med pass p	er	
	A Medication Ac	dministration Record,			month.Results of audits will to forwarded to QA committee	pe	
		2011, indicated the KCL			monthly x 6 months and qua	rterly	
		initialed as given on 9/29			thereafter.		
	lunch, or 9/30 lun	nch or "HS" [bedtime].					
		rd was reviewed again on					
		'.M. A Physician's order, dicated, "Ondonsetron					
	· · · · · · · · · · · · · · · · · · ·	n as Zofran, for nausea] 4					
	-	outh] QAM [every					
	"	rising et [and] PRN [as					
	needed] Q [every	7] 6-8 [hours]					
	l	x 7 days." A MAR, dated					
	_	licated a blank space on					
	· ·	initials on 8/27, 8/28,					
	and 8/29. Docum	he circled initials was					
	lacking.	ne circled initials was					
	nucking.						
	A Medication Ac	lministration Record,					
	•	2011, indicated, "Requip					
	_	et by mouth every					
		ess leg syndrome."					
		verse of the MAR					
		1 Unavailable. Unable to					
		3/11 Not able to give					
		able. Pharm faxed.					
		o give Requip. Fax					
	Pharm [sic]."						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING O			COMPL	x3) DATE SURVEY COMPLETED 10/06/2011			
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>	ST		DDRESS, CITY, STATE, ZIP CODE		
					CKHOFF RD /ILLE, IN47712		
	VER HEALTH CAN				/ILLE, IIN4// IZ	1	OLE.
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		D EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		AG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	DATE
	On 10/5/11 at 3::	50 P.M., during interview					
	with the Assistar	nt Director of Nursing,					
	she indicated she met with Resident B's						
	hospice nurse reg	garding the omission of					
		cated she did not know					
		staff did not administer					
	•	I not know why the					
	initials were circ	led on the MAR.					
	2 0 . 10/5/11	11.40 A M. I DNI // 1					
		11:40 A.M., LPN # 1					
	following medical	give Resident C the					
		ations. Lipitor, avix, Potassium Chloride,					
	· ·	N # 1 also administered					
	the resident Pron						
	supplement].	nou la vitainin					
	supplementj.						
	The clinical reco	ord of Resident C was					
	reviewed on 10/5	5/11 at 1:40 P.M. The					
	resident was adn	nitted to the facility on					
	9/28/11. Physicia	an orders, dated 9/28/11,					
	included the follo	owing medications:					
	Advair inhaler tw	vice daily, Docusate					
	Sodium twice da	ily, Lovenox daily, Lasix					
	twice daily, Imd	ur twice daily, Synthroid					
	daily, Lipitor dai	lly, Metoprolol daily,					
	Multivitamin dai	lly, Prilosec twice daily,					
	_	assium Chloride daily,					
		max daily and Tricor					
		an's order, dated 10/4/11,					
		od 30 cc TID [with] med					
	passes."						
	010/5/111	40 D.M. diament 1 - 4					
	On 10/5/11 at 1:4	40 P.M., the resident's					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TN4711

Facility ID: 012448

If continuation sheet

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155785		LDING	NSTRUCTION 00	(X3) DATE COMPI 10/06/2	ETED
	PROVIDER OR SUPPLIER		<i>5.</i> (12)	STREET A	DDRESS, CITY, STATE, ZIP CODE ICKHOFF RD VILLE, IN47712	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
	Medication Adm [MAR] was revie indicated the med Multivitamin, Pla and Flomax were "After rising." Pradministered "Up LPN # 1 indicate resident had been medications in the had been "splittin Documentation were ident had refured medications had different times. The resident's clireviewed on 10/5 Medication Record 2011, indicated in lacking for "All Lunch Meds," "A" "All Bedtime Med 9/30 "After Rising On 10/5/11 at 2:2 with the Administ facility was aware medication and of that corporate state for 2 weeks attention staff.	inistration Record ewed. The MAR dications Lipitor, avix, Potassium Chloride, e to be administered comod was to be con rise, Lunch, Supper." d at that time, that the me refusing some of the me morning, so the staff ing them up." was lacking that the sed medications, or that been administered at mical record was again foll at 2:40 P.M. A ord, dated September mitials and times were After Rising Meds," "All full Supper Meds," and ods," except for 9/29 and					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

TN4711

Facility ID: 012448

If continuation sheet

Page 24 of 29

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155785	A. BUII	LDING	NSTRUCTION 00	, ,	E SURVEY LETED 2011
		.00.00	B. WIN	_	ADDRESS, CITY, STATE, ZIP CO		
NAME OF I	PROVIDER OR SUPPLIEF	8			ICKHOFF RD	,DE	
WEST R	IVER HEALTH CAN	MPUS			VILLE, IN47712		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		esident A, he indicated					
	he had resided at						
	approximately 10 months, and during that time the staff had "mixed up" his						
		rs several times. Resident					
		e had been several times					
		et his medications and					
	creams.	et ms medicanons and					
	creams.						
	The clinical reco	ord of Resident A was					
	reviewed on 10/5/11 at 10:30 A.M.						
	A June 2011 Medication Administration						
		ncluded the following:					
	1 2	essure medication] 12.5					
		e 1 capsule by mouth					
		The entry for 6/8 was					
	blank. Entries or	1 6/10, 6/13, 6/14, 6/16,					
	6/17, and 6/18 w	ere circled initials.					
	Potassium Citrat	e Give 1 capsule three					
	times daily with	meals. Entries were blank					
	on 6/3 and 6/4 lu	nch, 6/4, 6/5, 6/6,					
	6/11-6/16 supper	r. Initials were circled on					
	6/17 and 6/18 su	pper, 6/18, breakfast and					
	lunch, and on 6/	19 after rising.					
	Doxycycline 100	mg [antibiotic] twice					
		An entry was blank on					
	6/5 supper. Kefle	ex 500 mg [antibiotic]					
		daily]. Entries were blank					
		supper, 6/5 supper, 6/6					
		to [left] great toe bid					
	1	weeks. Entries were					
	'	6, 6/4 at "6A-6P," and on					
	6/3, 6/4, 6/5, and	l 6/6 at "6P-6A." Nystop					

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155785		LDING	NSTRUCTION 00	COM	TE SURVEY MPLETED 5/2011	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 714 S EICKHOFF RD EVANSVILLE, IN47712					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION: CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	Entries were bland "6P-6A." Silvado after nystop pow Entries were bland "6P-6A." Entries on 6/2 at "6A-6P Explanation of the initials was lacking. A MAR, dated A Clean bilateral period in the blanks of the blank on 9/1, 9/1 and 9/28. Circled Explanation of the blank on 5/1, 9/1 and 9/28. Circled Explanation of the blank on 5/1, 9/1 and 9/28. Circled Explanation of the blanks on 5/1, 9/1 and 9/28. Circled Explanation of the blank on 5/1, 9/1 and 9/28. Circled Explanation of the blank on 5/1, 9/1 and 9/28. Circled Explanation of the blank on 5/1, 9/1 and 9/28. Circled Explanation of the blank on 5/1, 9/1 and 9/28. Circled Explanation of the blank on 5/1, 9/1 and 5/28.	ne blanks or circled ang. August 2011, included: osterior groin [with] pply silver powder. BD pad, wrap with kerlix. re blank from 8/25 atries with circled initials 29, and 8/30. Explanation circled initials was Reptember 2011, included: posterior groin [with] NS Apply silva powder to er [with] ABD [and] ix daily. Entries were 0, 9/11, 9/23, 9/24,9/25, d initials were on 9/26. he blanks or circled ang.						
	interview with the Director of Nurs	:30 A.M., during ne Corporate Nurses, ing, and Administrator, ere was a conflict at						

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO LDING	NSTRUCTION 00	COMP	E SURVEY LETED
		155785	B. WIN	IG		10/06/2	2011
	PROVIDER OR SUPPLIES			714 S E	ADDRESS, CITY, STATE, ZIP CO	DE .	
WESTR	IVER HEALTH CAN	//PUS		EVANS	VILLE, IN47712		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
IAG	times if the resid want to pay for a would not cover should be docum medication was a shis/her initials. a time of the provided times and inistering the ensure it is not properly to the provided time in the medication was a shis/her initials. The policy inclusting is designated at the provided time is designated at the provided time is designated at the provided time is usually by the provided time is usually by the provided time is usually by the provided time in the previous provided time of the previous provided to the previous provided the provid	lent or family did not medications that insurance and They indicated there mentation on why a missed. 4:00 P.M., the rovided the current facility cation Administration all Guidelines," undated. ded: "Unless a specific ed by the attending ations shall be the following times: a after there resident forning (morning is mes between 4 AM and 10 vice daily] - in the foedtime (bedtime is 1 PM to Midnight). c. TID for in the morning, me and at bedtime (lunch the edition of the editi		IAG	DEFICIENCY		DATE
	raministrator pr	ovided the current facility					1

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A DULL DIVIC 00			(X3) DATE SURVEY COMPLETED	
ANIAD I EARL	or condition	155785		LDING		10/06/2		
		.007.00	B. WIN		DDDECC CITY CTATE 7ID CODE	10/00/2	011	
NAME OF PROVIDER OR SUPPLIER					DDRESS, CITY, STATE, ZIP CODE			
WEST RIVER HEALTH CAMPUS					VILLE, IN47712			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA			
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE	
	policy on "Medication Administration -							
	General Guidelines," dated 2/10. The							
	policy included: "Medications are							
	administered in accordance with written							
	orders of the attending physicianAt the							
	end of each medication pass, the person							
	administering the medications reviews the							
	MAR to ensure necessary doses were							
	administered and documentedIf a dose							
	of regularly scheduled medication is							
	withheld, refused, or given at other that							
	the scheduled timethe space provided on							
	the front of the MAR for that dosage							
	administrations is (initialed and circled)							
	[sic]. An explanatory note is entered on							
		of the record provided for						
		documentation"						
	Traveus necuca							
	This federal tag relates to Complaint IN00096308.							
	3.1-50(a)(1)							
	3.1-50(a)(2)							
	3.1 30(u)(2)							

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155785	(X2) MULTIPI A. BUILDING B. WING	LE CONSTRUCTION 00		(X3) DATE S COMPL 10/06/20	ETED		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 714 S EICKHOFF RD EVANSVILLE, IN47712						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAC	PROVIDER'S X (EACH CORRECTI CROSS-REFERENC	PLAN OF CORRECTION IVE ACTION SHOULD BE CED TO THE APPROPRIA FICIENCY)	ΓE	(X5) COMPLETION DATE		

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